REIMBURSEMENT POLICY STATEMENT **GEORGIA MEDICAID**

Policy Name	Policy Number	Effective Date
Positive Airway Pressure Devices for Pulmonary Disorders	PY-0854	06/01/2020-04/30/2021

Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Table of Contents

A. Subject

Positive Airway Pressure Devices for Pulmonary Disorders

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Positive airway pressure (PAP) devices, involve using a machine that includes a mask or other device that fits over the nose and/or mouth to provide positive pressure to keep breathing airways open. Continuous positive airway pressure or CPAP is used to treat sleep-related breathing disorders including sleep apnea. It also may be used to treat preterm infants who have underdeveloped lungs. Bilevel or two level positive airway pressure or BiPAP is used to treat lung disorders such as chronic obstructive pulmonary disease (COPD). While CPAP delivers a single pressure, BiPAP delivers positive pressure both on inhalation and exhalation. PAP can provide better sleep quality, reduction or elimination of snoring, and less daytime sleepiness. The PAP machines should always be used according to the physician's order as well as every time during sleep at home, while traveling, and during naps in order to produce the most effective outcome.

C. Definitions

- **Compliance** - is defined as documented consistent use of PAP for either:
  - greater than or equal to (≥) four (4) hours for five (5) days each week for at least 70% of the time for a thirty (30) consecutive day period any time during the first three (3) months of coverage in the trial period;
  - average of four (4) hours per day of PAP availability.
- **Medically Necessary**- means the following: ○ care based upon generally accepted medical practices in light of conditions at the time of treatment.
  - is appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition.
  - is compatible with the standards of acceptable medical practice in the United States.
  - is provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.
  - is not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and
  - is not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

D. Policy

I. CareSource requires a prior authorization for PAP machines (CPAP/BiPAP).
   A. CPAP (E0601) and BiPAP (E0470, E0471 and E0472) machines are a 10 month rent to purchase. CareSource prior authorizations are for 3 months initial rental for PAP machines.
   B. After initial 3 months rental, providers must submit documentation for continued rental that shows the member's compliance with the use of the PAP machine during the first 3 months of use. Prior authorization may be obtain for the remaining rental period (months 4-10).

II. Providers that dispense the PAP machine must ensure and document the member's compliance with its use.
   A. Documentation that confirms compliance must be submitted along with the prior authorization request.
   B. Complianace for continued rental for members under 21 years of age is defined as: if criteria one (1) is met and one of criteria two (2) or three (3) are also met::
      1. There is documented improvement in sleep disruption, daytime sleepiness, and behavioral problems with use of the PAP, AND
      2. The member has been reevaluated for continued use of the PAP machine and demonstrates ongoing clinical benefit and compliance with use, defined as use of PAP for at least four (4) hours per night on 70% of the nights in a consecutive thirty (30) day period (remainder of the rental period considered for approval); OR
      3. The member has been reevaluated for continued use of the PAP within the first ninety (90) days and demonstrates ongoing clinical benefit from use of the device during periods of use, but due to pediatric age or conditions that affect behavior (autism, etc.) and the ability to meet standard compliance guidelines will be considered on a case-by-case basis through the prior approval process.
      4. Members that meet these criteria for extended coverage will be considered for reimbursement of the remaining seven (7) rental months. In order to receive the remaining seven (7) rentals in the ten (10) month rental period, the member must be compliant for at least two – four (2-4) hours per night on 40% of the nights in a consecutive thirty-day period.
   C. Compliance for continued rental for members 21 years of age or older is defined as: 1. Greater than or equal to (≥) four (4) hours for five (5) days each week for at least 70% of the time for a thirty (30) consecutive day period any time during the first three (3) months of coverage in the trial period or;
      2. Average of four (4) hours per day of CPAP availability

III. Member's that are not compliant with the use of their PAP machines will not be authorized further rental.
   A. Any reimbursement, for the PAP machine, that was dispensed during the time of noncompliance will be recouped by CareSource.
   B. Any reimbursement, for the supplies, that were dispensed during the time of noncompliance will be recouped by CareSource.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting Georgia Medicaid approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the Georgia Medicaid fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

CPT Code	Description
A4604	Tubing with integrated heating element for use with positive airway pressure device
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030	Full face mask used with positive airway pressure device, each
A7031	Face mask interface, replacement for full face mask, each
A7032	Cushion for use on nasal mask interface, replacement only, each
A7033	Pillow for use on nasal cannula type interface, replacement only, pair
A7034	Headgear used with positive airway pressure device
A7035	Headgear used with positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, nondisposable, used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device, each
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0561	Humidifier, non-heated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
E0601	Continuous positive airway pressure (CPAP) device
Modifiers	**Description**
RR	Rental (use the “RR”' modifier when DME is to be rented)
NU	New equipment (use the “NU” modifier when DME is purchased)

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	12/11/2019	New Policy
Date Revised		
Date Effective	06/01/2020	
Date Archived	04/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. CPAP - NHLBI, NIH. (2019, July 29). Retrieved 7/29/19 from https://www.nhlbi.nih.gov/healthtopics/cpap.
2. GA Medicaid DME Services Fee Schedule. (2019, July 1). Retrieved 7/29/19 from https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FEE%20SCHEDULES/Durable%20Medical%20Equipment%20Fee%20Schedule%20%2020190627123538.pdf
3. O.C.G.A. § 33-20A-31. (2019). Retrieved 7/29/19 from https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=afc7052b-2f4a-4323-932d7e3ac838e691&config=00JAA1MDBlYzczZi1lYjFlLTQxMTgtYWE3OS02YTgyOGM2NWJlMD YKAFBvZENhdGFsb2feed0oM9qoQOMCSJFX5qkd&pddocfullpath=%2fshared%2fdocument%2fstatutes-legislation%2furn%3acontentItem%3a5WF7-T1M0-004D-84YP-0000800&pddocid=urn%3acontentItem%3a5WF7-T1M0-004D-84YP-00008-00&pdcontentcomponentid=234186&pdteaserkey=sr0&pditab=allpods&ecomp=g5x8kkk&earg=sr0&prid=25b71602-4391-4514-966e-911df64f1edb.
4. POLICIES AND PROCEDURES for DURABLE MEDICAL EQUIPMENT SERVICES. (2019, July). Retrieved 7/29/19 from https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Part%20II%20Policies%20and%20Procedures%20for%20Durable%20Medical%20Equipment%20Services%20%2020190701130956.pdf

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-P-0881 12/11/2019 DCH Approved 03/02/2020